Loman Eye Care
"Protecting the Gift of Sight"

Patient History Questionnaire

Date_____

Name: Last_____ First_____ (Preferred)_____ MI_____ D.O.B_____

Address_____ City _____Zip Code_____ Sex ☐M ☐F

Telephone: (Home)_____ (Work)_____ (Cell)_____

SS#_____-_____-_____ Do you prefer to receive calls at: ☐Home ☐Work ☐Cell Text ok: ☐Yes ☐No

Email Address_____

Occupation_____Employer_____

Emergency contact_____ Relationship to patient_____ Phone #_____

Date of last eye exam_____ Doctor/Location_____

Whom may we thank for referring you? _____

Medical Insurance Information

Name of Insured (person who carries the insurance) _____

Insured's SS# _____-_____-_____ Insured's D.O.B. _____ Relationship to patient_____

Insured's Employer _____

Name of Vision Insurance Provider, if known (ex. VSP, Davis etc)_____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Ph#: _____ Address (if different from above) _____

_____

Signature of Patient (or parent if a minor) X_____ Date_____

Personal Eye Information

Do you currently wear glasses? ☐No ☐Yes - how old are your present glasses?_____

Are they your current prescription? ☐No ☐Yes Do you wear sunglasses? ☐No ☐Yes

Do you have problems with night vision? ☐No ☐Yes Do you use a computer? ☐No ☐Yes

Do you have problems with glare? ☐No ☐Yes

What hobbies/sports do you participate in?_____

Do you wear contact lenses? ☐No ☐Yes – brand_____

If NO: Are you interested in wearing contacts at this time? ☐No ☐Yes

Medical Information How would you describe your general health: ☐Excellent ☐Good ☐Fair ☐Poor

Are you **ALLERGIC** to any Medications? ☐No ☐Yes:_____

Do you have problems with: (if yes, please circle or write in)

☐No ☐Yes Eye- *glaucoma, macular degeneration, blindness, other*_____
☐No ☐Yes Cardiovascular- *heart disease, high blood pressure, other*_____
☐No ☐Yes Endocrine- *diabetes, thyroid, other*_____
☐No ☐Yes Genital, Kidney and Bladder- *infections, other*_____
☐No ☐Yes Ear, Nose and Throat- *sinus disorder, chronic cough, other*_____
☐No ☐Yes Psychiatric- *anxiety, depression, ADHD, schizophrenia, other*_____
☐No ☐Yes Musculoskeletal- *arthritis, back pain, other*_____
☐No ☐Yes Allergic/Immunologic- *lupus, hay fever, rheumatoid arthritis, other*_____
☐No ☐Yes Skin- *rosacea, skin cancer, psoriasis, other*_____
☐No ☐Yes Respiratory- *asthma, emphysema, other*_____
☐No ☐Yes Gastrointestinal- *ulcers, intestinal disease, other*_____
☐No ☐Yes Blood/Lymph- *bleeding disorder, anemia, other*_____
☐No ☐Yes Neurological- *multiple sclerosis, stroke, seizures, migraines, other*_____

Please list **ALL MEDICATIONS** you are currently taking:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Are you diabetic? ☐No ☐Yes How long? _____ Last A1C?_____

Please list any other health conditions:_____
_____

Do you use: Cigarettes/Tobacco: ☐ No ☐ Yes, Alcohol: ☐ No ☐ Yes, Other substances: ☐ No ☐ Yes

Name of family doctor: _____phone #_____

Have YOU ever been diagnosed with:

Glaucoma: ☐No ☐Yes
Dry Eye: ☐No ☐Yes
Cataracts: ☐No ☐Yes
Macular degeneration: ☐No ☐Yes
Retinal Detachment: ☐No ☐Yes
Amblyopia (lazy eye): ☐No ☐Yes

Other eye problems? explain_____

Have you had any eye operations? ☐No ☐Yes, type:_____Date_____

Have you had an eye injury? ☐No ☐Yes, kind:_____Date_____

Does anyone in your FAMILY have a history of:

☐ High blood pressure, who _____
☐ Diabetes, who _____
☐ Cataracts, who _____
☐ Macular Degeneration , who _____
☐ Retinal Detachment, who _____
☐ Glaucoma, who _____

Please review and sign below at each return visit

x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____
x_____ Date_____ x_____ Date_____

LOMAN
EYE CARE

Digital Retinal Imaging

Loman Eye Care is committed to providing our patients the most thorough eye health examination possible. We are pleased that we are able to perform Digital Retinal Imaging using a non mydriatic (no dilation needed) retinal camera that can aid the doctors in early detection of ocular disease & abnormalities.

If you are over 12 years of age OR have a history or family history of high blood pressure, diabetes, glaucoma or macular degeneration the doctors urge you to take advantage of this technology.

The cost is only $24.00. (Screenings are not covered by insurance)

Please indicate below:

_____ **Yes**, I want to receive the Digital Retinal Imaging at each comprehensive eye examination.

_____ **No**, I do not want to receive the Digital Retinal Imaging and acknowledge that this painless and non- invasive test is the best way to detect and monitor subtle changes in my eye health on an on-going basis.

Should you have any questions, please feel free to consult with the doctor.

* Dilation may be required for patients with small pupils.